Guidelines for Intensive Care Coordination

Authority

The following are guidelines for implementation of Intensive Care Coordination as required by statute, as follows:

2008 Session Adopted - Requires the State Executive Council to oversee the development and implementation of mandatory uniform guidelines for Intensive Care Coordination services for children who are at risk of entering, or are placed in, residential care through the Comprehensive Services Act program. The community policy and management team is responsible for establishing policies for providing Intensive Care Coordination services. The bill also requires family assessment and planning teams to identify children who are at risk of entering, or are placed in, residential care through the Comprehensive Services Act program who can be appropriately and effectively served in their homes, relatives' homes, family-like settings, and communities and coordinate services and develop a plan for returning the child to his home, relative's home, family-like setting, or community.

Virginia's Values for Intensive Care Coordination

Intensive Care Coordination shall be guided by the following values and shall be consistent with the state's practice model for children's services.

- We believe that all children deserve safe, nurturing and permanent homes and permanent family connections.

- We believe that child safety is first and foremost.

- We believe that parents have the right and responsibility to raise their own children.

- We believe that the family and youth perspective must be honored at all times during the service planning process and service options must reflect the family's values and preferences.

- We believe that all children can be served in the community. When exceptions to this must occur, placements out of the community are of the shortest duration possible.

- We believe that coordinating community services to transition or maintain children in their homes and communities is a public responsibility and that public community agencies should serve the community in this role.

Process for Developing the Guidelines

The guidelines build on the considerable work of a broad range of stakeholder groups, including the State Executive Council (SEC), the CSA State and Local Advisory Team (SLAT), the SLAT Care Coordination Workgroup and the resulting SLAT Case Management paper. Equally important, the experience of many communities, including the CSA Innovative Community Services Grantees and many other localities, who are already practicing Intensive Care Coordination was taken into consideration. The invaluable input of service providers who have taken the initiative to do Intensive Care Coordination has strongly influenced the development of these guidelines.

Definition of Intensive Care Coordination

Services conducted by an Intensive Care Coordinator, as defined under the State Executive Council guidelines, for children who are at risk of entering or who are placed in residential care. The purpose of the services are to safely and effectively maintain, transition, or return the child home or to a relative's home, family like setting, or community at the earliest appropriate time that addresses the child's needs. Services must be distinguished as above and beyond the regular case management services provided within the normal scope of responsibilities for the public child serving systems. Services and activities include:

- Identifying the strengths and needs of the child and his family through conducting or reviewing comprehensive assessments including, but not limited to, information gathered through the mandatory uniform assessment instrument;

- Identifying specific services and supports necessary to meet the identified needs of the child and his family, building upon the identified strengths;

- Implementing a plan for returning the youth to his home, relative's home, family-like setting, or community at the earliest appropriate time that addresses his needs, including identification of public or private community-based services to support the youth and his family during transition to community-based care;

- Implementing a plan for regular monitoring and utilization review of the services and residential placement for the child to determine whether the services and placement continue to provide the most appropriate and effective services for the child and his family.

(Does not include wraparound and community-based services which are reported in the community-based services category.)

Population to be Served by Intensive Care Coordination

Children should be identified to receive Intensive Care Coordination by their local Family Assessment and Planning team (FAPT). Eligible children include:

1. All children who are currently in residential care.

2. Children who are at risk of placement in residential care as identified by FAPTs.

Providers of Intensive Care Coordination

Providers. Providers of Intensive Care Coordination shall be Community Services Boards (CSBs). As the local agency for mental health, mental retardation and substance abuse services, the CSB is the public entry point for children needing care coordination services. A CSB may potentially contract with another entity to provide Intensive Care Coordination. In contracting for Intensive Care Coordination, the CSB must carefully consider how to assure that the CSB still serves as the public entry point for children needing services and that the contractual arrangement meets the needs of children, families and the community. If a CSB contracts with another entity to provide Intensive Care Coordination, the CSB nonetheless maintains full responsibility for Intensive Care Coordination, including monitoring the services provided under the contract. CSBs shall work in close collaboration with their Community Policy and Management Teams (CPMTs) and Family Assessment and Planning Teams (FAPTs) to implement Intensive Care Coordination and to assure that all children receive appropriate assessment and care planning. All children who receive Intensive Care Coordination must be reviewed by the FAPT. An Intensive Care Coordinator should facilitate the review process.

The Intensive Care Coordinator shall develop a plan of services to assure that the child's needs are met in the community. The perspective and preferences of the family and the youth shall be solicited and honored in developing the plan. The Intensive Care Coordinator and the Community Services Board do not necessarily have to provide any or all of the services. The Intensive Care Coordinator shall serve as a broker for arranging the needed services using the preferences of the family as a guide. Any provider may provide any of the services described in the plan, as long as the provider has the expertise and qualifications to assure quality service.

Staff. Staff shall be selected to provide Intensive Care Coordination consistent with the Position Description attached to these guidelines. Staff functions shall include a strengths discovery and assessment process, planning, coordination and monitoring, utilization review and other appropriate functions as needed to transition or maintain a child in the community. Intensive Care Coordination staff shall possess, at minimum, a Bachelor's degree with at least 2 years of experience in children's mental health services. Strong interpersonal skills and group facilitation skills are also essential.

Staff Supervision. Community Services Boards shall provide supervision for all Intensive Care Coordinators, including clinical supervision regarding specific cases, administrative supervision, coordination with CPMTs and FAPTs and supervision for clinical licensure when appropriate. Intensive Care Coordinators shall receive clinical supervision at least once per week. Supervisors shall possess, at minimum a Master's degree in social work, counseling, psychology or other related human services field and

be licensed-eligible with at least 4 years of experience in children's mental health services. Supervisors must also possess strong interpersonal skills and group facilitation skills. In addition, it is expected that supervisors will display leadership abilities and work closely with supervisors from other child serving systems to implement an organized system of care for children and families.

Caseload size. Caseload size should be sufficiently small to allow for the intensity required and is estimated to be 7 to 12 children. Specific caseloads shall be determined locally based on local need, complexity of cases, geographic differences (such as need to travel), time necessary to work with families to develop services and supports in preparation for the child's return home, and other locality-specific circumstances. The estimated caseload size of 7 to 12 children is based on the experience to date of localities currently providing Intensive Care Coordination. The Intensive Care Coordinator may need to work with each case an average of six to nine months to assure a successful transition from residential care.

Role. The Intensive Care Coordinator functions in collaboration with, and in addition to, other community staff with coordinating and case management roles, such as regular CSB case managers (providing targeted case management to larger caseloads), CSA Coordinators, FAPT coordinators, school system coordinators working on IEPS, child welfare and foster care workers, and others. The Intensive Care Coordinator has an in-depth clinical assessment role working with a very small caseload to plan and wrap services around a child. While a child is on the Intensive Care Coordinator's caseload, other service providers continue to have the responsibility to fulfill their respective roles.

Procedures for Implementing Intensive Care Coordination

1. All cases shall be referred to the Community Services Board for Intensive Care Coordination by the FAPT. Intensive Care Coordinators will work with the Community Policy and Management Team (CPMT) with FAPT input to develop a process for FAPTs to transition children from residential placements. CPMTs and FAPTs, with guidance from the intensive care coordinator, will be expected to review all children in residential care and determine which cases should be initially transitioned from residential care.

2. Parents, family members and youth shall be involved in a meaningful way that honors their choices and preferences in developing the service plan.

3. In referring children who are deemed to be at substantial risk of residential placement, the FAPT may want to consider, among other factors, the following:
    - The likelihood of residential placement within the next few months.
    - Other services that have been tried within the community setting.
    - Initial screening information provided by a CSB, including clinical and diagnostic information, as well as other information about the child's functioning in home, school and other community environments.

- If referred for residential care, the determination must be made that residential services are the least restrictive, most appropriate level of care that meets the child's current needs. Clear discharge criteria and a transition plan that notes how reintegration into the community will occur over time must be developed prior to initiating residential care. The transition plan must include target dates and milestones to be achieved (i.e. so many visits and treatment sessions at the program; so many day visits at home with treatment with clinician processing these visits, so many overnights with treatment with clinician processing these visits, etc.)

4. A comprehensive strengths discovery/assessment with the child and family shall be completed by the Intensive Care Coordinator on each child within 30 days of referral by the FAPT team.

5. The intensive care coordinator will begin the Individual and Family Services Plan (IFSP) based on the strengths discovery/assessment. The IFSP will be further defined through input from the family, the youth and the FAPT.

.

6. CPMTs shall fully support and facilitate the implementation of Intensive Care Coordination in their locality. CPMTs shall establish a local procedure for reimbursing CSBs for Intensive Care Coordination. Each CSB in collaboration with the local CPMT shall establish a rate for Intensive Care Coordination.

7. This case rate may be billed to CSA according to local procedures established by the CPMT.

Technical Assistance and Monitoring

- The Department of Mental Health, Mental Retardation and Substance Abuse Services and the Office of Comprehensive Services shall collaborate to provide technical assistance and monitoring of Intensive Care Coordination.

- Specific technical assistance activities and methods are under development. Technical assistance and monitoring may include statewide and/or regional meetings to focus on implementation of Intensive Care Coordination. Local governments that already provide Intensive Care Coordination will provide hands-on information to assist with start-up/troubleshooting.

- Review of management reports and monitoring of data submitted to the Office of Comprehensive Services to determine appropriate use of Intensive Care Coordination, caseload size, and statewide comparisons of service provision.

- Input from localities on technical assistance needs will shape these activities.

Attachments: Intensive Care Coordinator Position Description
Practice Model